DEPARTMENT OF LABOR AND INDUSTRY

CHAPTER 29

WORKERS COMPENSATION AND OCCUPATIONAL DISEASE

Subchapter 14

General Medical Rules and Facility Services Rules

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Subchapter 14

General Medical Rules and Facility Service Rules

Subchapter 15

Nonfacility Service Rules and Utilization Rules

Subchapter 14

General Medical Rules and Facility Service Rules

24.29.1401 INITIAL LIABILITY (1) Initial liability for payment of medical claims is the responsibility of the injured worker.

(2) After determination that the claim is covered under the Workers' Compensation or Occupational Disease acts, the liability for payment of the claim is the responsibility of the appropriate workers' compensation insurer.

(3) Pursuant to 39-71-743, MCA, when a claim is covered under the Workers' Compensation or Occupational Disease acts, providers may not bill the injured worker for the difference between the initial amount billed and the amount reimbursed to the provider by the insurer as set by applicable statutes and rules, except for the co-pay provided by 39-71-704, MCA.

(a) For injured workers who are receiving benefits from the Uninsured Employers' Fund pursuant to 39-71-503, MCA, the provisions of this rule are subject to 39-71-510, MCA.

(4) The injured worker is responsible for charges incurred for treatment of conditions which were not the result of the injury or for treatment when medical benefits have terminated according to 39-71-704, MCA. (History: 39-71-203, MCA; IMP, 39-71-510, 39-71-704, 39-71-743, MCA; Eff. 12/31/72; AMD, 1991 MAR p. 2622, Eff. 12/27/91; AMD, 2007 MAR p. 260, Eff. 2/23/07.)

24.29.1401A DEFINITIONS As used in subchapters 14 and 15, the following definitions apply:

(1) "Acute care hospital" or "hospital" means a health care facility appropriately licensed by the Department of Public Health and Human Services that provides inpatient and outpatient medical services to injured workers experiencing acute illness or trauma. Acute care hospitals are sometimes referred to as regulated hospitals.

(2) "Ambulatory Payment Classification (APC)" means the reimbursement system adopted by the department for outpatient services.

(3) "Ambulatory surgery center (ASC)" means a health care facility that operates primarily for the purpose of furnishing outpatient surgical services to patients.

(4) "Base rate" means the dollar value which is multiplied by the relative weight of the MS-DRG or APC to determine payment.

(5) "Bundling" means the practice of grouping multiple services, procedures, and supplies into one charge item instead of billing each separately.

(6) "CMS" means the Centers for Medicare and Medicaid Services.

(7) "Correct Coding Initiative (CCI)" means the code edits adopted by the department that are used to correct contradictory billing information.

(8) "Current Procedural Terminology (CPT)" codes means codes and descriptors of procedures owned, copyrighted, and published by the American Medical Association.

(9) "Documentation" means written information that is complete, clear, and legible, which describes the service provided and substantiates the charge for the service.

(10) "Durable medical equipment (DME)" means durable medical appliances or devices used in the treatment or management of a condition or complaint, along with associated nondurable materials and supplies required for use in conjunction with the appliance or device. The term does not include an implantable object or device.

(11) "Facility" or "health care facility" has the meaning provided under 50-5-101, MCA, and the administrative rules implementing that definition, and is limited to only those facilities licensed or certified by the Department of Public Health and Human Services.

(12) "Functional status" means written information that is complete, clear, and legible, that identifies objective findings indicating the claimant's physical capabilities and provides information about the change in the status as a result of treatment.

(13) "Healthcare Common Procedure Coding System (HCPCS)" means the identification system for health care matters developed by the federal government, and includes level one codes, known as CPT codes, and level two codes that were developed to use for supplies, procedures, or services that do not have a CPT code. These codes also include successor codes for CPT and HCPCS established by the American Medical Association and CMS.

(14) "Implantable" means a system of objects or devices that is made either to replace and act as a missing biological structure, to repair or support a biological structure, or to manage chronic disease processes and that is surgically implanted, embedded, inserted, or otherwise applied. The term also includes any related equipment necessary to install, operate, program, and recharge the implantable.

(15) "Improvement status" means written information that is complete, clear, and legible, which identifies objective medical findings of the claimant's medical status with respect to the treatment plan.

(16) "Inpatient services" means services rendered to a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that the patient will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use the hospital bed overnight. The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient.

(17) "Medicare-Severity Diagnosis Related Group (MS-DRG or DRG)" means the inpatient diagnosis classifications of circumstances where patients demonstrate similar resource consumption, length of stay patterns, and medical severity status that are adopted by the department and are used for billing purposes.

(18) "Nonfacility" means any place not included in this rule's definition of "facility".

(19) "Objective medical findings" means medical evidence that is substantiated by clinical findings. Clinical findings include, but are not limited to, range of motion, atrophy, muscle strength, muscle spasm, and diagnostic evidence. Complaints of pain in the absence of clinical findings are not considered objective medical findings.

(20) "Outpatient" means a patient who is not admitted for inpatient or residential care.

(21) "Physician" means those persons identified by 33-22-111, MCA, practicing within the scope of the providers' license.

(22) "Prior authorization" means that for those matters identified by ARM 24.29.1517 the provider receives (either verbally or in writing) authorization from the insurer to perform a specific procedure or series of related procedures, prior to performing that procedure.

(23) "Provider" means any health care provider, unless the context in another rule clearly indicates otherwise. "Provider" does not include pharmacists nor does it include a supplier of medical equipment who is not a health care provider.

(24) "Ratio of cost to charges (RCC)" means the computed ratio using charges and the hospital's Medicare cost report.

(25) "Relative Value Unit" or "RVU" represents a unit of measure for medical services, procedures, or supplies. RVU is used in the fee schedule formulas to calculate reimbursement fees and is expressed in numeric units. Those services that have greater costs or value have higher RVUs than those services with lower costs or value.

(26) "Resource-Based Relative Value Scale" or "RBRVS" means the publication titled "Essential RBRVS", published by Ingenix, Inc.

(27) "Service or services" means treatment including procedures and supplies provided in a facility or nonfacility that is billable under these rules.

(28) "Status indicator (SI)" codes mean CPT codes treated in the same fashion or category, such as packaged services, and apply to outpatient services only.

(29) "Treating physician" means:

(a) with respect to claims arising before July 1, 1993, the meaning provided by ARM 24.29.1511;

(b) with respect to claims arising on or after July 1, 1993, the meaning provided by 39-71-116, MCA.

(30) "Treatment plan" means a written outline of how the provider intends to treat a specific condition or complaint. The treatment plan must include a diagnosis of the condition, the specific type(s) of treatment, procedure, or modalities that will be employed, a timetable for the implementation and duration of the treatment, and the goal(s) or expected outcome of the treatment. Treatment, as used in this definition, may consist of diagnostic procedures that are reasonably necessary to refine or confirm a diagnosis. The treating physician may indicate that treatment is to be performed by a provider in a different field or specialty, and defer to the professional judgment of that provider in the selection of the most appropriate method of treatment; however, the treating physician must identify the scope of the referral in the treatment plan and provide guidance to the provider concerning the nature of the injury or occupational disease. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1993 MAR p. 2809, Eff. 12/1/93; AMD, 2002 MAR p. 1758, Eff. 7/1/02; AMD, 2007 MAR p. 1670, Eff. 10/26/07; TRANS from ARM 24.29.1504 and AMD, 2008 MAR p. 2490, Eff. 11/27/08.)

24.29.1402 PAYMENT OF MEDICAL CLAIMS (1) Payment of medical claims must be made in accordance with the schedule of facility and nonfacility medical fees adopted by the department.

(2) The insurer shall make timely payments of all medical claims for which liability is accepted.

(3) Payment of private room charges shall be made only if ordered by the treating physician.

(4) Special nurses shall be paid only if ordered by the treating physician.

(5) For claims arising before July 1, 1993, no fee or charge is payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer.

(6) For claims arising on or after July 1, 1993, no fee or charge is payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer, other than:

(a) the co-payment provided by 39-71-704, MCA. The decision whether to require a co-payment rests with the insurer, not the medical provider. If the insurer does not require a co-payment by the worker, the provider may not charge or bill the worker any fee. The insurer must give enough advance notice to known medical providers that it will require co-payments from a worker so that the provider can make arrangements with the worker to collect the co-payment;

(b) the charges for a nonpreferred provider, after notice is given as provided in 39-71-1102, MCA;

(c) the charges for medical services obtained from other than a managed care organization, once an organization is designated by the insurer as provided in 39-71-1101, MCA; or

(d) the charges for medical services denied by the insurer on the basis that the services meet both of the following criteria:

(i) the medical services do not return the injured worker to employment; and

(ii) the medical services do not sustain medical stability.

(7) For injured workers who are receiving benefits from the Uninsured Employers' Fund pursuant to 39-71-503, MCA, the provisions of this rule are subject to 39-71-510, MCA. (History: 39-71-203, MCA; IMP, 39-71-203, 39-71-510, 39-71-704, MCA; Eff. 12/31/72; AMD, 1991 MAR p. 2622, Eff. 12/27/91; AMD, 1993 MAR p. 2801, Eff. 12/1/93; AMD, 2007 MAR p. 260, Eff. 2/23/07; AMD, 2008 MAR p. 2490, Eff. 11/27/08.)

24.29.1403 SELECTION OF PHYSICIAN (REPEALED) (History: 39-71-203, MCA; IMP, 39-71-203, 39-71-704, MCA; Eff. 12/31/72; AMD, 1991 MAR p. 2622, Eff. 12/27/91; REP, 1993 MAR p. 404, Eff. 4/1/93.)

24.29.1404 DISPUTED MEDICAL CLAIMS (1) After mediation, disputes between an insurer and a medical service provider arising over the amount of a fee for medical services are resolved by a hearing before the department upon written application of a party to the dispute or the injured worker. The following issues are considered to be disputes arising over the amount of a fee for medical services:

(a) amounts payable to medical providers, when benefits available directly to claimants are not an issue;

(b) access to medical records;

(c) timeliness of payments to medical providers; or

(d) requirements for documentation submitted by a provider to an insurer pursuant to ARM 24.29.1513 as a condition of the payment of medical fees.

(2) All other disputes arising over medical claims, including travel expense reimbursement to injured workers, shall be brought before a department mediator as provided in part 24 of the Workers' Compensation Act.

(3) Facility records must be furnished to the insurer upon request. Facilities must obtain the necessary release by their administrative procedures.

(4) The rule of privileged communication is waived by the injured worker seeking benefits under the Workers' Compensation or Occupational Disease acts. (History: 39-71-203, MCA; IMP, 39-71-203, 39-71-704, MCA; Eff. 12/31/72; AMD, 1991 MAR p. 2622, Eff. 12/27/91; AMD, 2007 MAR p. 260, Eff. 2/23/07; AMD, 2007 MAR p. 1670, Eff. 10/26/07; AMD, 2008 MAR p. 2490, Eff. 11/27/08.)

24.29.1405 PHYSICIANS' REPORTS (REPEALED) (History: 39-71-203, MCA; IMP, 39-71-203, 39-71-704, MCA; Eff. 12/31/72; AMD, 1991 MAR p. 2622, Eff. 12/27/91; REP, 1993 MAR p. 404, Eff. 4/1/93.)

24.29.1406 FACILITY BILLS (1) Facility bills should be submitted when the injured worker is discharged from the facility or every 30 days.

(2) To the extent possible, electronic billing must be utilized by both providers and payers in the billing and reimbursement process to facilitate the rapid transmission of data, lessen the opportunity for errors, and lessen system costs.

(3) It is the responsibility of the facility to use the proper service codes on any bills submitted for payment. The failure of a provider to do so, however, does not relieve the insurer's obligation to pay the bill, but it may justify delays in payment until proper coding of the services provided is received by the insurer.

(4) Except as provided in (3), insurers must make timely payments of facility bills. In cases where there is no dispute over liability for the condition, the insurer must, within 30 days of receipt of a facility's charges, pay the charges according to the rates established by these rules.

(5) Insurer-initiated medical necessity review, claim audits, and other administrative review procedures may only be conducted on a post-payment basis. (History: 39-71-203, MCA; IMP, 39-71-105, 39-71-107, 39-71-203, 39-71-704, MCA; Eff. 12/31/72; AMD, 2008 MAR p. 2490, Eff. 12/1/08.)

24.29.1407 PROSTHETIC APPLIANCES (1) Claims for furnishing replacement or repair of prosthetic appliances shall be paid to orthotists or prosthetists, who have been certified by the American Board for Certification in Orthotics or Prosthetics, and whose services are performed in a certified facility. (History: 39-71-203, MCA; IMP, 39-71-203, 39-71-704, MCA; Eff. 12/31/72.)

24.29.1408 SUSPENSION ALLOWED (1) An insurer may suspend compensation payments under 39-71-607, MCA, for not more than 30 days pending the receipt of medical information, if:

(a) the insurer submits to the department a detailed written statement indicating that the insurer is having difficulty in receiving medical information relating to a claimant's condition; and

(b) the department approves a suspension of compensation payments for not more than 30 days pending the receipt of medical information; and

(c) after the department approves the suspension of payments, the insurer notifies the claimant in writing that biweekly payments are being suspended pending the receipt of medical information. A copy of the notification shall be furnished to the department. (History: 39-71-607, MCA; IMP, 39-71-607, MCA; NEW, Eff. 1/3/76.)

24.29.1409 TRAVEL EXPENSE REIMBURSEMENT (1) For claims arising before July 1, 1989, reimbursement for travel expenses shall be determined as follows:

(a) Personal automobile and private airplane mileage expenses shall be reimbursed at the current rates specified for state employees. Prior authorization from the insurer is required for the use of a private airplane. Total reimbursable automobile miles shall be determined according to the most direct highway route between the injured worker's residence and the provider.

(b) Expenses for eligible meals shall be reimbursed at the meal rates established for state employees.

(c) Actual out-of-pocket receipted lodging expenses incurred by injured workers shall be reimbursed up to the maximum amounts established for state employees. Lodging in those areas specifically designated as high cost cities shall be reimbursed at actual cost. Any claim for receipted or high cost lodging reimbursement must be accompanied by an original receipt from a licensed lodging facility. If the injured worker stays in a nonreceiptable facility, or fails to obtain a receipt, the reimbursement is the amount set for state employees for nonreceipted lodging.

(d) Miscellaneous transportation expenses, such as taxi fares or parking fees, are reimbursable and must be supported by paid receipts.

(e) Requests for travel reimbursement must be made within a reasonable time following the date(s) the travel was incurred.

(2) For claims arising during the period July 1, 1989, through June 30, 1993, reimbursement for travel expenses shall be determined as follows:

(a) Personal automobile and private airplane mileage expenses shall be reimbursed at the current rates specified for state employees. Prior authorization from the insurer is required for the use of a private airplane. Total reimbursable automobile miles shall be determined according to the most direct highway route between the injured worker's residence and the provider. When the travel coincides in whole or in part with the injured worker's regular travel to or from the worker's employment, the coincident mileage may be subtracted from the reimbursable mileage. For each calendar month, the first 50 miles of automobile mileage is not reimbursable.

(b) Expenses for eligible meals shall be reimbursed at the meal rates established for state employees.

(c) Actual out-of-pocket receipted lodging expenses incurred by injured workers shall be reimbursed up to the maximum amounts established for state employees. Lodging in those areas specifically designated as high cost cities shall be reimbursed at actual cost. Any claim for receipted or high cost lodging reimbursement must be accompanied by an original receipt from a licensed lodging facility. If the injured worker stays in a nonreceiptable facility, or fails to obtain a receipt, the reimbursement is the amount set for state employees for nonreceipted lodging.

(d) Miscellaneous transportation expenses, such as taxi fares or parking fees, are reimbursable and must be supported by paid receipts.

(e) Claims for reimbursement of travel expenses must be submitted within 90 days of the date the expenses are incurred, on a form furnished by the insurer. Claims for reimbursement that are not submitted within 90 days may be denied by the insurer.

(3) For claims arising from July 1, 1993, through June 30, 2001, travel expenses are not reimbursed unless the travel is at the request of the insurer. Travel is "at the request of the insurer" when the insurer directs the claimant to: change treating physician; attend an independent medical examination; use a preferred provider; or be treated by a managed care organization. If travel expenses are to be reimbursed, then reimbursement shall be determined as follows:

(a) Personal automobile and private airplane mileage expenses shall be reimbursed at the current rates specified for state employees. Prior authorization from the insurer is required for the use of a private airplane. Total reimbursable automobile miles shall be determined according to the most direct highway route between the injured worker's residence and the provider. For each calendar month, the first 50 miles of automobile mileage is not reimbursable. In addition, travel within the community in which the worker resides shall not be reimbursed.

(b) Expenses for eligible meals shall be reimbursed at the meal rates established for state employees.

(c) Actual out-of-pocket receipted lodging expenses incurred by injured workers shall be reimbursed up to the maximum amounts established for state employees. Lodging in those areas specifically designated as high cost cities shall be reimbursed at actual cost. Any claim for receipted or high cost lodging reimbursement must be accompanied by an original receipt from a licensed lodging facility. If the injured worker stays in a nonreceiptable facility, or fails to obtain a receipt, the reimbursement is the amount set for state employees for nonreceipted lodging.

(d) Miscellaneous transportation expenses, such as taxi fares or parking fees, are reimbursable and must be supported by paid receipts.

(e) Claims for reimbursement of travel expenses must be submitted within 90 days of the date the expenses are incurred, on a form furnished by the insurer. Claims for reimbursement that are not submitted within 90 days may be denied by the insurer.

(4) For claims arising on or after July 1, 2001, payment of travel expense is subject to the following:

(a) Claims for reimbursement of travel expenses must be submitted within 90 days of the date the expenses are incurred, on a form furnished by the insurer. Claims for travel expense reimbursement that are not submitted within 90 days may be denied by the insurer. The insurer must notify the injured worker in writing that the request for travel expense reimbursement must be submitted within 90 days from the date the expense was incurred in order to be reimbursed. If the insurer fails to notify the claimant of the claimant's entitlement to travel expenses and 90 days have passed since the expense was incurred, the insurer must pay the travel.

(b) The type of travel selected must be the least costly form of travel unless the travel is not suitable for the claimant’s medical condition, as certified by the claimant's physician.

(c) Reimbursement of travel is excluded under the following conditions:

(i) The first 100 miles of automobile travel are excluded each month unless the insurer requested the travel pursuant to 39-71-605, MCA.

(ii) Travel to a medical provider within the claimant’s community is excluded.

(iii) Travel outside the claimant’s community is excluded if comparable treatment is available within the community, unless the insurer requests the claimant to travel to another community.

(iv) Travel is excluded when it is incurred while traveling to unauthorized or disallowed treatment or procedures.

(d) For purposes of this rule, "community" means the area within a 15 mile radius of the claimant's residence as determined by the most direct automobile route between the claimant's residence and the provider.

(e) The insurer is not liable for injuries that result from an accident that occurs during travel for treatment of the claim as provided in 39-71-704, MCA.

(f) Reimbursement for travel expenses shall be determined as follows:

(i) Personal automobile and private airplane mileage expenses shall be reimbursed at the current rates specified for state employees. Prior authorization from the insurer is required for the use of a private airplane. Total reimbursable automobile miles shall be determined according to the most direct highway route between the claimant's residence and the provider.

(ii) Expenses for eligible meals shall be reimbursed at the meal rates established for state employees.

(iii) Actual out-of-pocket receipted lodging expenses incurred by the claimant shall be reimbursed up to the maximum amounts established for state employees. Lodging in those areas specifically designated as high cost cities shall be reimbursed at actual cost. Any claim for receipted or high cost lodging reimbursement must be accompanied by an original receipt from a licensed lodging facility. If the claimant stays in a nonreceiptable facility, or fails to obtain a receipt, the reimbursement is the amount set for state employees for nonreceipted lodging.

(iv) Miscellaneous transportation expenses, such as taxi fares or parking fees, are reimbursable and must be supported by paid receipts.

(5) Preauthorized expenses incurred for direct commercial transportation by air or ground, including rental vehicles, shall be reimbursed when no other less costly form of travel is available to the claimant, or when less costly forms of travel are not suitable to the claimant's medical condition, as certified by the claimant's physician.

(a) If a claimant chooses to use commercial transportation when a less costly form of travel suitable to the claimant's medical condition is available, as certified by the claimant's physician, reimbursement shall be made according to the rates associated with the least costly form of travel.

(6) For occupational disease claims arising prior to July 1, 2005, if liability has not been accepted on the claim and the department schedules a medical examination as provided in 39-72-602, MCA, the insurer shall reimburse the claimant for the travel expenses incurred for the examination pursuant to this rule.

(7) The department shall make available to interested parties the specific information referenced in this rule concerning rates for transportation, meals, and lodging; meal time ranges; and designations of high cost cities. The department shall inform interested parties in a timely manner of all applicable updates to this information. (History: 39-71-203, 39-72-203, 39-72-402, MCA; IMP, 39-71-704, 39-72-602, 39-72-608, MCA; NEW, 1990 MAR p. 1564, Eff. 8/17/90; AMD, 1993 MAR p. 2804, Eff. 12/1/93; AMD, 2006 MAR p. 210, Eff. 1/27/06.)

Rules 24.29.1410 through 24.29.1414 reserved

24.29.1415 IMPAIRMENT RATING DISPUTE PROCEDURE (1) This section applies to dates of injury beginning July 1, 1987, through June 30, 1991. An evaluator must be a qualified physician licensed to practice in the state of Montana under Title 37, chapter 3, MCA, and board certified in an area of specialty appropriate to the injury of the claimant, except that if the claimant's treating physician is a chiropractor, the evaluator may be a chiropractor who is certified as an impairment evaluator under Title 37, chapter 12, MCA. The claimant's treating physician may not be one of the evaluators to whom the claimant is directed by the department.

(2) The department shall arrange evaluations as close to the claimant's residence as reasonably possible.

(3) The department shall give written notice to the parties of the time and place of the examination. If the claimant fails to give 48 hours notice of the claimant's inability to attend the examination, the claimant is liable for payment of the evaluator's charges.

(4) The department may request a party to submit all pertinent medical documents including any previous impairment evaluations to the selected evaluator.

(5) Any party wanting to provide information to an evaluator or inquire about the status of an evaluation shall do so only through the department.

(6) The impairment evaluators shall operate according to the following procedures:

(a) The evaluator shall submit a report of the evaluator's findings to the department, claimant, and insurer within 15 days of the date of the examination.

(b) If another evaluation is requested within 15 days after the first evaluator mailed the first report, the department shall select a second evaluator who shall render an impairment evaluation of the claimant.

(c) The second evaluator shall submit a report of the second evaluator's findings to the department, claimant, and insurer, within 15 days of the date of the examination.

(d) The department shall submit both reports to the third evaluator, who shall then submit a final report to the department, claimant, and insurer within 30 days of the date of the examination or, if no examination is conducted, within 30 days of receipt of the first and second evaluation reports from the department. The final report must certify that the other two evaluators have been consulted.

(e) If neither party disputes the rating in the final report, the insurer shall begin paying the impairment award, if any, within 45 days of the third evaluator's mailing of the report.

(f) Either party may dispute the final impairment rating by filing a petition with the workers' compensation court within 15 days of the third evaluator's mailing of the report. (History: 39-71-203, MCA; IMP, 39-71-711, MCA; NEW, 1987 MAR p. 1985, Eff. 10/30/87; AMD, 1990 MAR p. 1004, Eff. 6/1/90; AMD, 1991 MAR p. 2622, Eff. 12/27/91; AMD, 2007 MAR p. 260, Eff. 2/23/07.)

24.29.1416 APPLICABILITY OF DATE OF INJURY, DATE OF SERVICE

(1) The amounts of the following types of payments are determined according to the specific department rates in effect on the date the medical service or services are provided, regardless of the date of injury:

(a) medical fees;

(b) facility charges;

(c) prescription drugs; and

(d) DME.

(2) When services, procedures, or supplies are bundled for purposes of billing and the bundling covers more than one day, the date of discharge must be used as the date the services are provided for purposes of this rule. (History: 39-71-203, MCA; IMP, 39-71-704, 39-71-727, MCA; NEW, 1991 MAR p. 2622, Eff. 12/27/91; AMD, 1994 MAR p. 679, Eff. 4/1/94; AMD, 2007 MAR p. 1192, Eff. 8/24/07; AMD, 2008 MAR p. 2490 Eff. 11/27/08.)

Rules 24.29.1417 through 24.29.1419 reserved

24.29.1420 RELATIVE VALUE FEE SCHEDULE (REPEALED) (History: 39-71-203, 39-71-704, MCA, as amended by section 3 of Ch. 422 of Laws of 1985; IMP, 39-71-704, MCA; NEW, 1986 MAR p. 454, Eff. 4/1/86; REP, 1993 MAR p. 404, Eff. 4/1/93.)

Rules 24.29.1421 through 24.29.1424 reserved

24.29.1425 RATES FOR HOSPITAL SERVICES PROVIDED PRIOR TO JULY 1, 1997 (1) Beginning January 1, 1988, through December 31, 1991, hospital rates payable by workers' compensation insurers shall not exceed those rates prevailing in the hospital in effect on January 1, 1988.

(2) Beginning January 1, 1992, hospital rates payable shall not exceed the product of the rates prevailing in the hospital and the applicable discount factor issued by the department. Applicable discount factors are identified for inpatient services according to the date of discharge, and for outpatient services according to the date of service. The department shall establish discount factors according to the following methodology:

(a) The discount factor in effect for a hospital beginning January 1, 1992, is the discount factor in effect on December 31, 1991, multiplied by 1.0402, and divided by the quantity 1 + ORI, where ORI is the overall percent rate increase, if any, adopted by the hospital for January 1, 1992, divided by 100. Discount factors in effect December 31, 1991, are those established by the department in accordance with (1). These discount factors are available from the department upon request.

(b) The discount factor in effect for a hospital beginning January 1, 1993, is the discount factor in effect on December 31, 1992, multiplied by the quantity 1 + AWW93, and divided by the quantity 1 + ORI, where AWW93 is the percent increase in the state's average weekly wage over fiscal year 1992, divided by 100, and ORI is the overall percent rate increase, if any, adopted by the hospital for January 1, 1993, divided by 100.

(c) In addition to the dates given in (2)(a) and (2)(b), the discount factor for a hospital is also updated on any date(s) through December 31, 1993, for which a rate change is adopted by the hospital. The discount factor in effect beginning the date of rate adoption is the previous discount factor divided by the quantity 1 + ORI, where ORI is the overall percent rate increase adopted by the hospital, divided by 100.

(3)(a) The discount factor in effect for a hospital from January 1, 1994 through June 30, 1997, is the discount factor in effect on December 31 of the previous year, multiplied by the quantity 1 + AWW (current year), and divided by the quantity 1 + ORI, where AWW (current year) is the percentage increase in the state's average weekly wage over the previous calendar year, divided by 100, and ORI is the overall percentage rate increase, if any, adopted by the hospital on January 1, divided by 100.

(b) In addition to the dates given in (3)(a), the discount factor for a hospital is also updated on any date(s) through June 30, 1997, for which a rate change is adopted by the hospital. The discount factor in effect beginning the date of rate adoption is the previous discount factor divided by the quantity 1 + ORI, where ORI is the overall percentage rate increase adopted by the hospital, divided by 100.

(4) The overall rate increase adopted by a hospital shall be reported to the department on a department-approved form before the effective date of any rate change. Notification by the Montana hospitals rate review system of the amount and date of an overall rate increase shall be accepted in lieu of direct rate change reporting by the hospital. The department may in its discretion conduct audits of any hospital's financial records, to determine proper reporting of rate filings.

(5) Charges billed by a hospital are not subject to reduction under the Montana relative value fee schedule, except that hospital professional fees may be paid according to either the fee schedule or the applicable hospital rates, but not both.

(6) Insurers shall make timely payments of hospital bills. In cases where there is no dispute over liability the insurer shall, within 30 days of receipt of a hospital's charges, either pay the charges according to the rates established by this rule, or notify the hospital that additional information is requested, and specify that information. The insurer shall then pay the charges within 30 days of receipt of the requested information. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1987 MAR p. 2388, Eff. 1/1/88; AMD, 1991 MAR p. 2622, Eff. 12/27/91; AMD, 1998 MAR p. 759, Eff. 4/1/98.)

24.29.1426 HOSPITAL SERVICE RULES FOR SERVICES PROVIDED FROM APRIL 1, 1998, THROUGH DECEMBER 31, 2007 (1) Any overall rate change adopted by a hospital shall be reported to the department on a department-approved form before the effective date of the rate change. The department may in its discretion conduct audits of any hospital's financial records to determine proper reporting of rate change filings.

(2) Charges billed by a hospital are not subject to reduction under the Montana relative value fee schedule, except that hospital professional fees may be paid according to either the fee schedule or the applicable hospital rates, but not both. In the event that the department adopts a relative value fee schedule for out-patient services, this rule will be amended.

(3) Insurers shall make timely payments of hospital bills. In cases where there is no dispute over liability the insurer shall, within 30 days of receipt of a hospital's charges, either pay the charges according to the rates established by these rules, or notify the hospital that additional information is requested, and specify that information. The insurer shall then pay the charges within 30 days of receipt of the requested information. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1998 MAR p. 759, Eff. 4/1/98; AMD, 2007 MAR p. 1670, Eff. 10/26/07.)

24.29.1427 HOSPITAL SERVICE RULES FOR SERVICES PROVIDED FROM JANUARY 1, 2008, THROUGH NOVEMBER 30, 2008 (1) This rule applies to services provided from January 1, 2008, through November 30, 2008.

(2) Any overall rate change adopted by a hospital shall be reported to the department on a department-approved form before the effective date of the rate change. The department may in its discretion conduct audits of any hospital's financial records to determine proper reporting of rate change filings.

(3) Insurers shall make timely payments of hospital bills. In cases where there is no dispute over liability the insurer shall, within 30 days of receipt of a hospital's charges, either pay the charges according to the rates established by these rules, or notify the hospital that additional information is requested, and specify that information. The insurer shall then pay the charges within 30 days of receipt of the requested information. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2007 MAR p. 1670, Eff. 10/26/07; AMD, 2008 MAR p. 2490, Eff. 12/1/08.)

24.29.1428 HOSPITAL RATES FOR JULY 1, 1997, THROUGH JUNE 30, 1998 (1) For hospital services rendered by a hospital not licensed as a medical assistance facility under Title 50, chapter 5, MCA, the amount payable by an insurer for those services performed during the period starting July 1, 1997, and ending March 31, 1998, is the higher of:

(a) 69 percent of the hospital's usual and customary charges, as those charges were in existence for the hospital on January 1, 1997; or

(b) the discount factor established by the department that was in effect on June 30, 1997, as calculated pursuant to ARM 24.29.1425.

(2) Starting April 1, 1998, for hospital services rendered by a hospital, other than one licensed as a medical assistance facility under Title 50, chapter 5, MCA, that changes its usual and customary charges between January 1, 1997, and June 30, 1998, must have its rates adjusted by the use of a discount factor. The discount factor is computed by taking the existing discount factor for that hospital, divided by the quantity 1 + ORI, where ORI is the overall percentage rate change adopted by the hospital, divided by 100.

(3) As an example of the application of this rule, if a hospital changes its rates between January 1, 1997, and June 30, 1998, the discount factor is adjusted before determining whether use of (1)(a) or (1)(b) above yields the greater payment. Assume that a hospital's January 1, 1997 discount factor is .5655 and the hospital increases its rates by 2 percent on March 1. The rate provided by (1)(a) is calculated as follows: A $100 charge times 69 percent yields a $69.00 payment. If rates are increased by 2 percent, the $69.00 payment divided by the increased amount billed of $102 yields an adjusted discount factor of .6765. The rate provided by (1)(b) is calculated as follows: A $100 charge times the discount factor, which in this example is .5655 yields a payment of $56.55. If rates have been increased by 2 percent, the $56.55 payment divided by the increased amount billed of $102 yields an adjusted discount factor of .5544. Because (1)(a) yields a $69.00 payment with a discount factor of .6765 and (1)(b) only yields a $56.55 payment with a discount factor of .5544, the greater payment is chosen. The discount factor for the hospital in this example is established as .6765, and is effective for services rendered on or after April 1, 1998. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1998 MAR p. 759, Eff. 4/1/98.)

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24.29.1430 HOSPITAL RATES FROM JULY 1, 1998, THROUGH JUNE 30, 2001 (1) Any hospital, other than one licensed as a medical assistance facility under Title 50, chapter 5, MCA, that changes its usual and customary charges on or after July 1, 1998, must have its rates adjusted by the use of a discount factor. The discount factor is computed by taking the existing discount factor for that hospital, divided by the quantity 1 + ORI, where ORI is the overall percentage rate change adopted by the hospital, divided by 100.

(2) For hospital services rendered by a hospital not licensed as a medical assistance facility under Title 50, chapter 5, MCA, the amount payable by an insurer for those services performed during the fiscal year starting July 1, 1998, is that hospital's discount factor in effect on June 30, 1998, plus the percentage increase in the state's average weekly wage. The adjusted discount factor is computed by multiplying the existing discount factor for that hospital times (1 + the percentage increase).

(3) The department will thereafter recalculate each hospital's discount factor to take into account changes to the hospital's usual and customary charges. The department will also annually recalculate, effective July 1 of each year, each hospital's discount factor to take into account the percentage increase in the state's average weekly wages made during the previous calendar year. If for any year the state's average weekly wage does not increase, the rates will be held at the existing level until there is a net increase in the state's average weekly wage. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1998 MAR p. 759, Eff. 4/1/98; AMD, 2007 MAR p. 260, Eff. 2/23/07; AMD, 2008 MAR p. 2490, Eff. 11/27/08.)

24.29.1431 HOSPITAL RATES FROM JULY 1, 2001, THROUGH NOVEMBER 30, 2008 (1) Any hospital, other than one licensed as a medical assistance facility or critical access hospital under Title 50, chapter 5, MCA, that changes its usual and customary charges on or after July 1, 2001, must have its rates adjusted by the use of a discount factor. The discount factor is computed by taking the existing discount factor for that hospital, divided by the quantity 1 + ORI, where ORI is the overall percentage rate change adopted by the hospital, divided by 100.

(2) For hospital services rendered by a hospital not licensed as a medical assistance facility or critical access hospital under Title 50, chapter 5, MCA, the amount payable by an insurer for those services performed during the fiscal year starting July 1, 2001, is that hospital's discount factor in effect on June 30, 2001, plus the percentage increase in the state's average weekly wage. The adjusted discount factor is computed by multiplying the existing discount factor for that hospital times (1 + the percentage increase).

(3) The department will thereafter recalculate each hospital's discount factor to take into account changes to the hospital's usual and customary charges. The department will also annually recalculate, effective July 1 of each year, each hospital's discount factor to take into account the percentage increase in the state's average weekly wages made during the previous calendar year. If for any year the state's average weekly wage does not increase, the rates will be held at the existing level until there is a net increase in the state's average weekly wage. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2007 MAR p. 260, Eff. 2/23/07; AMD, 2008 MAR p. 2490, Eff. 12/1/08.)

NEW RULE I (ARM 24.29.1432) FACILITY SERVICE RULES AND RATES FOR SERVICES PROVIDED ON OR AFTER DECEMBER 1, 2008

(1) The department adopts the fee schedules provided by this rule to determine the reimbursement amounts for medical services provided at a facility when a person is discharged on or after December 1, 2008. An insurer is obligated to pay the fee provided by the fee schedules for a service, even if the billed charges are less, unless the facility and insurer have a managed care organization (MCO) or preferred provider organization (PPO) arrangement that provides for a different payment amount. The fee schedules, available on-line via the internet at http://erd.dli.mt.gov/wcregs/medreg.asp, are comprised of the following elements:

(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule, based on CMS version 26;

(b) The Montana Hospital Outpatient and ASC Fee Schedule Organized by APC;

(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS;

(d) The Montana Ambulance Fee Schedule;

(e) The Montana CCI Code Edits Listing;

(f) The Montana RCC and other Montana RCC-based Calculations;

(g) The Montana Status Indicator (SI) Codes; and

(h) The base rates and conversion formulas established by the department.

(2) The application of the base rate depends on the date the medical services are provided.

(3) Critical access hospitals and medical assistance facilities are reimbursed at 100 percent of that facility's usual and customary charges.

(4) Any services provided by a type of facility not explicitly addressed by this rule must be paid at 75 percent of its usual and customary charges.

(5) Any inpatient rehabilitation services, including services provided at a long term inpatient rehabilitation facility must be paid at 75 percent of that facility's usual and customary charges. All CMS rehabilitation MS-DRGs are excluded from the Montana MS-DRG payment system and instead are paid at 75 percent of the facility's usual and customary charges regardless of the place of service.

(6) DME, prosthetics, and orthotics, excluding implantables, will be paid at 75 percent of a facility's usual and customary charges.

(7) Facility billing must be submitted on a CMS Uniform Billing (UB-04) form or CMS 1500 form, including the 837-I and 837-P form when submitting electronically.

(8) Hospitals and ASCs must, on an annual basis, submit to the department data reporting Medicare, Medicaid, commercial, unrecovered, and workers' compensation claims reimbursement in a standard form supplied by the department. The department may in its discretion conduct audits of any facility's financial records to confirm the accuracy of submitted information.

(9) Individual medical providers who furnish professional services in a hospital, ASC, or other facility setting must bill insurers separately and must be reimbursed using the nonfacility fee schedule. Those reimbursements are excluded from any calculation of outlier payments.

(10) Facility pharmacy reimbursements are made as follows:

(a) If a facility pharmacy dispenses prescription drugs to an individual during the course of treatment in the facility, reimbursement is part of the MS-DRG or APC reimbursement.

(b) If a patient's medications are not included in the MS-DRG or APC service bundle, the reimbursement will be 75 percent of the facility's usual and customary charges.

(11) The following applies to inpatient services provided at an acute care hospital:

(11) The following applies to inpatient services provided at an acute care hospital:

(a) The department may establish the base rate annually.

(i) Effective December 1, 2008, the base rate is $7,735.

(b) Payments for inpatient acute care hospital services must be calculated using the base rate multiplied by the Montana MS-DRG weight. For example, if the MS-DRG weight is 0.5, the amount payable is $3,867.50, which is the base rate of $7,735 multiplied by 0.5.

(c) If a service falls outside of the scope of the MS-DRG and is not otherwise listed on a Montana fee schedule, reimbursement for that service must be 75 percent of that facility's usual and customary charges.

(d) The threshold for outlier payments is three times the Montana MS-DRG payment amount. If the outlier threshold is met, the outlier payment must be the MS-DRG reimbursement amount plus an amount that is determined by multiplying the charges above the threshold by the sum of 15 percent and the individual hospital's Montana operating RCC.

(i) For example, if the hospital submits total charges of $100,000, the MS-DRG reimbursement amount is $25,000, and the RCC is 0.50, then the resultant calculation for reimbursement is as follows: The DRG reimbursement amount ($25,000) is multiplied by 3 to set the threshold trigger ($75,000). The threshold trigger ($75,000) is subtracted from the total charges ($100,000) resulting in the amount above the trigger ($25,000). The amount above the trigger ($25,000) is then multiplied by .65 (which is the RCC of .5 plus .15) to obtain the outlier payment ($16,250). The total payment to the hospital in this example would be the DRG reimbursement amount ($25,000) plus the outlier payment ($16,250) = $41,250.

(ii) The department may establish the inpatient outlier amount annually.

(e) Where an implantable exceeds $10,000 in cost, hospitals may seek additional reimbursement beyond the normal MS-DRG payment. Any implantable that costs less than $10,000 is bundled in the implantable charge included in the MS-DRG payment.

(i) Any reimbursement for implantables pursuant to this subsection must be documented by a copy of the invoice for the implantable. Insurers are subject to privacy laws concerning disclosure of health or proprietary information.

(ii) Reimbursement is set at a total amount that is determined by adding the actual amount paid for the implantable on the invoice, plus the handling and freight cost for the implantable, plus 15 percent of the actual amount paid for the implantable. Handling and freight charges must be included in the implantable reimbursement and are not to be reimbursed separately.

(iii) When a hospital seeks additional reimbursement pursuant to this subsection, the implantable charge is excluded from any calculation for an outlier payment.

(iv) Because the decision regarding an implantable is a complex medical analysis, this rule defers to the judgment of the individual physician and facility to determine the appropriate implantable. A payer may not reduce the reimbursement when the medical decision is to use a higher cost implantable.

(f) All facility services provided during an uninterrupted patient encounter leading to an inpatient admission must be included in the inpatient stay, except air and ground ambulance services which are paid separately pursuant to the Montana Ambulance Fee schedule.

(g) The following applies to facility transfers when a patient is transferred for continuation of medical treatment between two acute care hospitals:

(i) A hospital transferring a patient is paid as follows: The MS-DRG reimbursement amount is divided by the geometric mean number of days duration listed for the MS-DRG; the resultant per diem amount is then multiplied by two for the first day of stay at the transferring hospital; the per diem amount is multiplied by one for each subsequent geometric mean day of stay at the transferring hospital; and the amounts for each day of stay at the transferring hospital are totaled. If the result is greater than the MS-DRG reimbursement amount, the transferring hospital is paid the MS-DRG reimbursement amount. Associated outliers and add-ons are then added to the payment.

(ii) A hospital receiving a patient is paid the full MS-DRG payment plus any appropriate outliers and add-ons.

(iii) Facility transfers do not include costs related to transportation of a patient to initially obtain medical care. Such reimbursements are covered by ARM 24.29.1409.

(12) The following applies to outpatient services provided at an acute care hospital or an ASC:

(a) The department may establish the base rate for outpatient service at acute care hospitals annually.

(i) Effective December 1, 2008, the base rate for hospital outpatient services is $105.

(b) The department may establish the base rate for ASCs annually.

(i) Effective December 1, 2008, the base rate for ASCs is $79, which is 75 percent of the hospital base rate.

(c) Payments for outpatient services in a hospital or an ASC are based on the Montana APC system. A single outpatient visit may result in more than one APC for that claim. The payment must be calculated by multiplying the base rate times the APC weight. If the APC weight is not listed or if the APC weight is listed as null, reimbursement for that service must be paid at 75 percent of the facility's usual and customary charges. Examples of such services include but are not limited to laboratory tests, radiology, and therapies. If a service falls outside of the scope of the APC and is not otherwise listed on a Montana fee schedule, reimbursement for that service must be 75 percent of that facility's usual and customary charges.

(d) CCI code edits must be used to determine bundling and unbundling of charges. No other clinical editing is allowed to determine bundling and unbundling of charges.

(e) Outpatient medical services include observation in an outpatient status.

(f) Where an outpatient implantable exceeds $500 in cost, hospitals or ASCs may seek additional reimbursement beyond the normal APC payment. In such an instance, the provider may bill CPT code L 8699, and the status indicator code "N" may not be used by a payer to determine the amount of the payment. Any implantable that costs less than $500 is bundled in the APC payment.

(i) Any reimbursement for implantables pursuant to this subsection must be documented by a copy of the invoice for the implantable. Insurers are subject to privacy laws concerning disclosure of health or proprietary information.

(ii) Reimbursement is set at a total amount that is determined by adding the actual amount paid for the implantable on the invoice, plus the handling and freight cost for the implantable, plus 15 percent of the actual amount paid for the implantable. Handling and freight charges must be included in the implantable reimbursement and are not to be reimbursed separately.

(g) The following applies to patient transfers from an ASC to an acute care hospital:

(i) An ASC transferring a patient is paid the APC reimbursement.

(ii) The acute care hospital is paid the MS-DRG or the APC reimbursement, whichever is applicable.

(iii) Facility transfers do not include costs related to transportation of a patient to initially obtain medical care. Such reimbursements are covered by ARM 24.29.1409. (History: 39-71-203, MCA; IMP, 39-71-203, 39-71-704, MCA; NEW, 2008 MAR p. 2490, Eff. 12/1/08.)